		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044750

Facility Name: COMMUNITY NSG & REHAB CTR

Address: 1136 NORTH MILL STREET (Number) NAPERVILLE (City) 60563 (Zip Code)

County: DUPAGE

Telephone Number: (630) 355-3300 **Fax #** (630) 355-1417

IDPA ID Number: 3643458778001

Date of Initial License for Current Owners: 04/01/2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARK WELDLER
(Title) CFO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	48	Skilled (SNF)	48	17,520	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	55,845	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	32,068	8,543	5,857	46,468	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,068	8,543	5,857	46,468	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.21%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 4,994

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	295,163	31,784	7,478	334,425		334,425		334,425			1
2	Food Purchase		237,986		237,986		237,986	(9,660)	228,326			2
3	Housekeeping	170,228	35,443		205,671		205,671		205,671			3
4	Laundry	36,103	22,714		58,817		58,817		58,817			4
5	Heat and Other Utilities			146,989	146,989		146,989		146,989			5
6	Maintenance	33,811	5,929	49,478	89,218		89,218	18,110	107,328			6
7	Other (specify):*			8,619	8,619		8,619		8,619			7
8	TOTAL General Services	535,305	333,856	212,564	1,081,725		1,081,725	8,450	1,090,175			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,510,739	54,108	55,273	2,620,120		2,620,120		2,620,120			10
10a	Therapy	78,466			78,466		78,466		78,466			10a
11	Activities	97,019	6,024		103,043		103,043		103,043			11
12	Social Services	37,084			37,084		37,084		37,084			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,723,308	60,132	85,273	2,868,713		2,868,713		2,868,713			16
	C. General Administration											
17	Administrative	140,000			140,000		140,000		140,000			17
18	Directors Fees											18
19	Professional Services			41,708	41,708		41,708	8,000	49,708			19
20	Dues, Fees, Subscriptions & Promotions			37,219	37,219		37,219	(22,577)	14,642			20
21	Clerical & General Office Expenses	174,806	16,822	26,343	217,971		217,971	(39,800)	178,171			21
22	Employee Benefits & Payroll Taxes			577,185	577,185		577,185		577,185			22
23	Inservice Training & Education											23
24	Travel and Seminar			560	560		560		560			24
25	Other Admin. Staff Transportation			1,543	1,543		1,543		1,543			25
26	Insurance-Prop.Liab.Malpractice			234,494	234,494		234,494		234,494			26
27	Other (specify):*			25,750	25,750		25,750	(25,750)				27
28	TOTAL General Administration	314,806	16,822	944,802	1,276,430		1,276,430	(80,127)	1,196,303			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,573,419	410,810	1,242,639	5,226,868		5,226,868	(71,677)	5,155,191			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: COMMUNITY NSG & REHAB CTR #0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,478	
	REPAIRS & MAINTENANCE		0	
			0	7,478
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		59,766	
	ELECTRICITY		61,179	
	WATER		26,044	
	CABLE TV - LOBBY		0	
			0	146,989
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,356	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		36,662	
	ELEVATOR MAINTENANCE & REPAIR		6,540	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,920	
	FIRE SERVICE		0	
			0	
			0	
			0	49,478
7	**OTHER**			
	SCAVENGER		8,619	
	SECURITY SERVICE		0	8,619
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	30,000	30,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	42,613	
	LABORATORY & XRAY EXPENSE		12,068	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	592	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	55,273
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COMMUNITY NSG & REHAB CTR #0044750 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,893	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	13,815	
			0	41,708
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	15,028	
	EMPLOYEE WANT ADS	XIX F	3,158	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,339	
	LICENSES & PERMITS	XIX F	1,745	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	7,549	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	400	37,219
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		9,310	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,033	
	MESSENGER SERVICE		0	
			0	26,343

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	252,229	
	UNEMPLOYMENT COMPENSATION	XIX D	28,630	
	WORKERS COMPENSATION INSURANCI	XIX D	130,764	
	HOSPITALIZATION INSURANCE	XIX D	147,717	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,707	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	9,138	
	CHICAGO HEAD TAX	XIX D	0	577,185
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	560	
	TRAVEL	XIX G	0	
			0	
			0	560
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,543	1,543
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		234,494	234,494
27	**OTHER**			
	BAD DEBTS	VI 24	25,750	
			0	25,750

GRAND TOTAL COLUMN 3 OTHER 1,242,639

Facility Name & ID Number COMMUNITY NSG & REHAB CTR #0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			157,770	157,770		157,770	89,412	247,182			30
31	Amortization of Pre-Op. & Org.			600	600		600		600			31
32	Interest			29,873	29,873		29,873	243,313	273,186			32
33	Real Estate Taxes							114,137	114,137			33
34	Rent-Facility & Grounds			672,587	672,587		672,587	(672,587)				34
35	Rent-Equipment & Vehicles			10,524	10,524		10,524		10,524			35
36	Other (specify):*											36
37	**TOTAL Ownership**			871,354	871,354		871,354	(225,725)	645,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,555	278,010	546,565		546,565		546,565			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,772	83,772		83,772		83,772			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		268,555	361,782	630,337		630,337		630,337			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,573,419	679,365	2,475,775	6,728,559		6,728,559	(297,402)	6,431,157			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,056)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,204)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,604)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(25,750)	27		24
25	Fund Raising, Advertising and Promotional	(15,028)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,549)	20		28
29	Other-Attach Schedule	(13,890)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,081)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(210,321)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (210,321)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (297,402)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COMMUNITY NSG & REHAB CTR

ID# 0044750

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 18,110	6	1
2	MARKETING SALARIES	(40,000)	21	2
3	ACCOUNTING FEES	8,000	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,890)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,660)	0	0	0	0	0	0	0	0	0	0	(9,660)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	18,110	0	0	0	0	0	0	0	0	0	0	18,110	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	8,450	0	0	0	0	0	0	0	0	0	0	8,450	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	8,000	0	0	0	0	0	0	0	0	0	0	8,000	19
20	Fees, Subscriptions & Promotions	(22,577)	0	0	0	0	0	0	0	0	0	0	(22,577)	20
21	Clerical & General Office Expenses	(40,000)	200	0	0	0	0	0	0	0	0	0	(39,800)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(25,750)	0	0	0	0	0	0	0	0	0	0	(25,750)	27
28	**TOTAL General Administration**	(80,327)	200	0	0	0	0	0	0	0	0	0	(80,127)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(71,877)	200	0	0	0	0	0	0	0	0	0	(71,677)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(15,204)	104,616	0	0	0	0	0	0	0	0	0	89,412	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	243,313	0	0	0	0	0	0	0	0	0	243,313	32
33	Real Estate Taxes	0	114,137	0	0	0	0	0	0	0	0	0	114,137	33
34	Rent-Facility & Grounds	0	(672,587)	0	0	0	0	0	0	0	0	0	(672,587)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(15,204)	(210,521)	0	0	0	0	0	0	0	0	0	(225,725)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(87,081)	(210,321)	0	0	0	0	0	0	0	0	0	(297,402)	45

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARK AND CHANA WELDLER	29.50			COMMUNITY NURSING u		
STEVE AND BLUMA JEREMIAS	29.50	WHEATON CARE CENTER	WHEATON	REHABILITATION REALTY		
MALKA MERMELSTEIN	0.50	LAKEFRONT HEALTHCARE CENTER, INC.	CHICAGO	LLC	NAPERVILLE	REAL ESTATE
HERMAN MERMELSTEIN	0.50					
JOSEPH NEUMANN	30.00					
HIRSCH WOLF	10.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	CLERICAL & GEN. OFFICE	$	COMMUNITY NURSING & REHAB. REALTY, LLC	100.00%	$ 200	$ 200	1
2	V	30	DEPRECIATION		" "		104,616	104,616	2
3	V	32	AMORTIZATION		" "		10,740	10,740	3
4	V	32	INTEREST EXPENSE		" "		232,573	232,573	4
5	V	33	PROPERTY TAXES		" "		114,137	114,137	5
6	V	34	RENT EXPENSE	672,587	" "			(672,587)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 672,587			$ 462,266	$ * (210,321)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STEVE JEREMIAS	ADMINISTRATOR	ADMINISTRATIV	29.50	SEE ATTACHED	50	100.00	SALARY	$ 70,000	17-1	1
2	MARK WELDLER	CFO		29.50		50	100.00	SALARY	70,000	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 140,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY:						$	$			$	1
2	AMERICAN NAT'L BANK		X	MORTGAGE	$22,916.67	03/31/00	5,500,000	4,812,500	03/31/05	PRIME+	232,573	2
3				MORTGAGE COST			53,702	13,427			10,740	3
4												4
5												5
	Working Capital											
6	AMERICAN NAT'L BANK		X	WORKING CAPITAL	DEMAND	03/31/00	1,000,000	571,000		5.2500	29,873	6
7												7
8												8
9	TOTAL Facility Related				$22,916.67		$ 6,553,702	$ 5,396,927			$ 273,186	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,553,702	$ 5,396,927			$ 273,186	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	96,540	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	114,137	2
3. Under or (over) accrual (line 2 minus line 1).	$	17,597	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	96,540	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	114,137	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999	95,684	9
2000	97,858	10
2001	109,400	11
2002	114,137	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY NSG & REHAB CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-12-403-042	NURSING HOME	$ 114,137.14	$ 114,137.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 114,137.14	$ 114,137.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,087 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,000
2. Number of Years Over Which it is Being Amortized: 5 YEARS
3. Current Period Amortization: 600
4. Dates Incurred: 04/01/00

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	164,335		$ 453,622	1
2					2
3	TOTALS	164,335		$ 453,622	3

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	153		2000	1986	$ 4,184,589	$ 104,616	40	$ 104,616	$	$ 392,307	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE			2000	4,305	108	40	108		405	9
10	ELEVATOR DOOR			2000	4,389	110	40	110		403	10
11	PARKING LOT			2000	38,200	955	40	955		3,502	11
12	LANDSCAPING			2000	8,736	218	40	218		781	12
13	SIGN			2000	4,541	114	40	114		408	13
14	ARCHITECT FEES			2000	3,060	77	40	77		286	14
15	DOOR LOCK			2000	2,248	56	40	56		201	15
16	CLOSETS			2000	7,729	193	40	193		659	16
17	COVE BASE			2000	4,459	111	40	111		361	17
18	HANDRAILS AND KICKPLATES			2000	15,146	379	40	379		1,232	18
19	LIGHTING			2000	65,796	1,645	40	1,645		5,346	19
20	TILE			2000	2,317	58	40	58		188	20
21	FLOORING			2000	16,378	409	40	409		1,280	21
22	EXIT DOORS			2000	1,598	40	40	40		130	22
23	WINDOW AND CUBICLE TREATMENTS			2000	34,021	851	40	851		2,766	23
24	LIGHTING			2000	1,729	43	40	43		140	24
25	CARPETING			2000	27,139	678	40	678		2,204	25
26	FIRE PANEL			2000	4,500	113	40	113		367	26
27	NURSE'S STATION			2000	8,913	223	40	223		706	27
28	DOOR HANDLES			2000	1,644	41	40	41		130	28
29	CUBICLE TRACK			2000	915	23	40	23		71	29
30	MOTOR			2000	13,276	332	40	332		1,162	30
31	STOVE HOODS			2000	1,429	36	40	36		111	31
32	COVER BASE - RESIDENTS' TOOMS			2001	865	87	10	87		253	32
33	CERAMIC TILES			2001	10,930	1,093	10	1,093		3,188	33
34	CEILING & LIGHTING			2001	9,063	906	10	906		2,543	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	RENOVATIONS - THERAPY ROOM	2001	$ 10,558	$ 1,056	10	$ 1,056	$	$ 3,081	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10	233		699	38
39	SHAMPOO STATION	2001	5,431	543	10	543		1,584	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	170		496	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	140		409	41
42	ABS PUMP	2001	11,908	1,191	10	1,191		3,474	42
43	CARPETING	2001	14,572	1,457	10	1,457		4,250	43
44	FLOORING	2001	1,320	132	10	132		385	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	3,888		10,692	45
46	AVERY	2001	2,419	242	10	242		665	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	228		646	47
48	WALLCOVERINGS	2001	12,289	1,229	10	1,229		3,687	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	313		835	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	200		534	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	1,786		4,762	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	172		458	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	952		2,539	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	264		704	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	2,054		5,306	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	140		350	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,335		4,865	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	141		329	58
59	KITCHEN TILE	2001	930	93	10	93		209	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,386		3,119	60
61	CARPETING	2001	5,729	573	10	573		1,480	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10	2,044		6,132	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	1,188		3,267	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	450		1,163	64
65	NEW DOORS	2002	1,731	173	10	173		260	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	700	10	700		1,050	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	630	10	630		945	67
68	WINDOW MOLDINGS	2002	210	21	10	21		32	68
69	NEW THRESHHOLDS	2002	205	21	10	21		31	69
70	TOTAL (lines 4 thru 69)		$ 4,739,340	$ 139,660		$ 139,660	$	$ 489,568	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,739,340	$ 139,660		$ 139,660	$	$ 489,568	1
2	NEW PVC PIPING IN KITCHEN	2002	1,320	132	10	132		198	2
3	UPGRADE BACKFLOW SYSTEM	2002	1,695	170	10	170		255	3
4	ALARM FOR RAMP EXIT	2002	1,443	144	10	144		216	4
5	FLOORING IN ELEVATOR	2002	856	86	10	86		129	5
6	CORNER GUARDS/WATER SOFTENER	2002	1,328	133	10	133		199	6
7	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	999	10	999		1,498	7
8	CORNER GUARDS	2003	276	28	10	28		28	8
9	UPGRADE DIALYSIS ROOM	2003	28,103	2,810	10	2,810		2,810	9
10	NEW AWNINGS FOR PATIO	2003	3,940	394	10	394		394	10
11	INSTALL GREASE TRAP IN KITCHEN	2003	3,250	325	10	325		325	11
12	NEW COIL FOR AIR HANDLER	2003	3,493	349	10	349		349	12
13	INSTALL LASER EYE ON ELEVATOR	2003	1,590	159	10	159		159	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,796,619	$ 145,389		$ 145,389	$	$ 496,128	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,001,350	$ 112,319	$ 100,135	$ (12,184)	10	$ 372,426	71
72	Current Year Purchases	20,136	4,027	1,007	(3,020)	10	1,007	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,021,486	$ 116,346	$ 101,142	$ (15,204)		$ 373,433	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1988 FORD ECONOLINE	2000	$ 3,255	$ 651	$ 651	$	5	$ 2,441	76
77										77
78										78
79										79
80	TOTALS			$ 3,255	$ 651	$ 651	$		$ 2,441	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,274,982	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 262,386	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 247,182	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,204)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 872,002	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 4,419 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	1999 ACURA	$ 579.00	$ 6,105	17
18					18
19					19
20					20
21	TOTAL		$ 579.00	$ 6,105	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 17,096	$		$ 17,096	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,076			14,076	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			197,901			197,901	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				268,555		268,555	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	INHALATIONAL THERAPY Other (specify):	39-3				48,937			48,937	13
14	TOTAL			$		$ 278,010	$ 268,555		$ 546,565	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 552,399	$ 553,474	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 8,700)	1,031,818	1,031,818	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	208,136	208,136	6
7	Other Prepaid Expenses	7,500	7,500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,799,853	$ 1,800,928	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	612,031	612,031	15
16	Equipment, at Historical Cost	1,133,402	1,133,402	16
17	Accumulated Depreciation (book methods)	(494,899)	(887,208)	17
18	Deferred Charges		13,427	18
19	Organization & Pre-Operating Costs	3,000	3,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,250)	(2,250)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,251,284	$ 5,510,613	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,051,137	$ 7,311,541	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 690,762	$ 690,762	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	169,816	169,816	28
29	Short-Term Notes Payable	2,169,952	971,000	29
30	Accrued Salaries Payable	51,742	51,742	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,166	21,166	31
32	Accrued Real Estate Taxes(Sch.IX-B)		96,540	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,103,438	$ 2,001,026	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,812,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,812,500	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,103,438	$ 6,813,526	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (52,301)	$ 498,015	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,051,137	$ 7,311,541	48

*(See instructions.)

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 173,931	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(2,363)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 171,568	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(223,869)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (223,869)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (52,301)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,394,897	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,394,897	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	104,607	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 104,607	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,552	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	274	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,360	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,186	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,504,690	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,081,725	31
32	Health Care	2,868,713	32
33	General Administration	1,276,430	33
	B. Capital Expense		
34	Ownership	871,354	34
	C. Ancillary Expense		
35	Special Cost Centers	546,565	35
36	Provider Participation Fee	83,772	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,728,559	40
41	**Income before Income Taxes (line 30 minus line 40)****	(223,869)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (223,869)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,169	$ 73,864	$ 34.05	1
2	Assistant Director of Nursing	1,698	1,778	51,806	29.14	2
3	Registered Nurses	25,299	26,947	693,992	25.75	3
4	Licensed Practical Nurses	14,882	15,739	300,886	19.12	4
5	Nurse Aides & Orderlies	83,262	88,134	1,246,311	14.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,939	4,338	78,466	18.09	8
9	Activity Director	1,896	2,080	30,569	14.70	9
10	Activity Assistants	7,192	7,579	66,450	8.77	10
11	Social Service Workers	1,984	2,080	37,084	17.83	11
12	Dietician					12
13	Food Service Supervisor	7,372	8,164	89,494	10.96	13
14	Head Cook	6,597	6,969	87,584	12.57	14
15	Cook Helpers/Assistants	13,449	13,962	118,085	8.46	15
16	Dishwashers					16
17	Maintenance Workers	2,216	2,388	33,811	14.16	17
18	Housekeepers	20,607	21,959	170,228	7.75	18
19	Laundry	4,000	4,424	36,103	8.16	19
20	Administrator	2,600	2,600	140,000	53.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,763	11,576	174,806	15.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,577	2,822	35,823	12.69	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	5,186	5,522	108,057	19.57	33
34	TOTAL (lines 1 - 33)	217,503	231,230	$ 3,573,419 *	$ 15.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	186	$ 7,478	1-3	35
36	Medical Director	MONTHLY	30,000	9-3	36
37	Medical Records Consultant	MONTHLY	592	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	186	$ 38,070		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,579	$ 42,613	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,579	$ 42,613		53

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEVE JEREMIAS	ADMIN	29.50	$ 70,000
MARK WELDLER	CFO	29.5	70,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,000

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEMS, INC	DATA PROCESSING	$ 12,817
POWER SOFTWARE	DATA PROCESSING	3,514
PAYCHEX	DATA PROCESSING	5,958
ACCU-MED SERVICES	DATA PROCESSING	3,340
INTERNET	COMPUTER SERVICES	25
XO-DSL	COMPUTER SERVICES	129
PERSONNEL PLANNERS	U C CONSULTANT	1,417
MEDI.COM	DATA PROCESSING	1,313
MEYER MAGENCE	LEGAL FEES	2,438
SACHNOFF & WEAVER	LEGAL FEES	296
AMERICAN EXPRESS	ACCOUNTING FEES	9,664
IVANS	DATA PROCESSING	797
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,708

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,764
Unemployment Compensation Insurance	28,630
FICA Taxes	252,229
Employee Health Insurance	147,717
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	8,707
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	9,138
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,158
Health Care Worker Background Check	400
(Indicate # of checks performed 65)	
MARKETING/ADV/PROMO	22,577
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	1,745
DUES & SUBSCRIPTIONS	9,339
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(15,028)
Yellow page advertising	(7,549)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,642

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	560
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 560

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	09/2000	$ 108,663		$ 18,110	$ 36,221	$ 36,222	$ 18,110	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 108,663		$ 18,110	$ 36,221	$ 36,222	$ 18,110	$	$	$	$	$

Facility Name & ID Number COMMUNITY NSG & REHAB CTR # 0044750 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE-&9218**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **83,772**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees